Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

| | | | | |
|---|---|---|---|---|
| STUDENT'S NAME: *(LAST)* | *(FIRST)* | *(M.I.)* | DATE (MM/DD/YY) | |
| | | | STUDENT ID. # | |

# MULTI-TIERED SYSTEM OF SUPPORTS (MTSS)
# VISION SCREENING

## VISION SCREENING REPORT

ADDRESS _____
City State Zip Code

TELEPHONE_____ SEX_____ BIRTHDATE_____

SCHOOL_____ GRADE_____ ETHNICITY_____

PARENT/GUARDIAN _____ TEACHER _____

Reason for referral:

_____

_____

| | RIGHT | LEFT | BOTH |
|---|---|---|---|
| Visual acuity without glasses: | | | |
| Visual acuity with present glasses: | | | |
| Visual acuity with prescription recommended: | | | |

Results and Recommendation Summary:

_____

_____

Date of Examination: _____

_____
Name of Examiner

_____
Title of Examiner

_____
Signature of Examiner